Va. DMHMRSAS Pharmacy, Therapeutics Formulary Committee
Formulary Modification Request Form

Section I. Formulary modification request Form (Petitioner):

_____Addition _____Deletion _____Restricted access (*if restricted, please provide conditions for restriction):*

_____

Section II: Drug information & Clinical Justification (Petitioner): *attach additional sheets if necessary*

- Generic Name_____ Trade Name(s)_____
- Manufacturer(s): _____
- Mechanism of action: _____

_____

- Usual dose, frequency, and duration of therapy:

_____

- Comparable drug(s) on formulary: _____

_____

_____

- Situations in which this drug is superior to those on formulary:

_____

_____

- Should we consider deleting any items from the Formulary because of this drug? __ Yes __ No
- Special cautions and restrictions in use (list): _____

_____

- Pertinent literature references – *include Cost effectiveness data* (Please attach):

_____

- Suggested criteria for use: (Please attach additional sheets if necessary)

1. Guidelines: _____

_____

2. Monitoring parameters (including adverse drug reactions/interactions that may occur; preventive and/or responsive management for each:_____

_____

_____

3. Outcome measures (markers to determine drug efficacy):

_____

_____

This form is used to request modifications to the Va. DMHMRSAS PT&F Formulary. Modifications may only be requested by CSB physicians, facility prescribers or pharmacists, or through needs identified by the Pharmacy, Therapeutic & Formulary Committee.

We reserve the right to return this form to the petitioner if all portions of this form are not completed.

Completed forms: forward to the Community Resource Pharmacy (pharmacy retain original), Attn: Pharmacy Manager; Box 4030, Petersburg, VA. 23803. Send copies to Central Office, Attention: Medical Director / Clinical Pharmacy Services; fax (804) 786-8623, Va. DMHMRSAS or Mail: Medical Director / Clinical Pharmacy Services, DMHMRSAS; Jefferson Bldg; 1220 Bank Street, Richmond, VA. 23220

MEDIS

_____

Section III. Conflict of Interest (Petitioner):

• Have you been an investigator in any research study involving the use of this drug?

__ Yes __ No

• Within the last two years, have you served as an advisor, received honoraria from the company manufacturing or promoting this product? ___Yes ___No

*If you answered yes to either one of these questions, please provide further details of your relationship:*_____

_____

_____

_____

Section IV. Petitioner information:

Requested by: _____ **Date:**_____

Printed name: _____

Associated CSB / Facility_____

Physician's Beeper No./ contact information: _____

Section V: Additional Information (Pharmacy Services)

Pharmacist receiving request:_____ **Date:** _____

Acquisition cost: $_____

Estimated Annual cost impact (direct costs): $_____

Section VI: Review (Pharmacy / PTF Committee):

Recommendation accepted.

Recommendation denied. *If formulary recommendation is denied, document rationale below.*

Rational_____

_____

_____

_____

Drug Name and suggested dose:_____

We reserve the right to return this form to the petitioner if all portions of this form are not completed.

Completed forms: forward to the Community Resource Pharmacy (pharmacy retain original), Attn: Pharmacy Manager; Box 4030, Petersburg, VA. 23803. Send copies to Central Office, Attention: Medical Director / Clinical Pharmacy Services; fax (804) 786-8623, Va. DMHMRSAS or Mail: Medical Director / Clinical Pharmacy Services, DMHMRSAS; Jefferson Bldg; 1220 Bank Street, Richmond, VA. 23220

MEDIS